Mind Matters ECHO

Module: Depression
Session 5: Managing Suicidal Patients in Primary Care

September 14, 2021

Mount Sinai Health Partners

Welcome!

- Pre-survey: bitly.com/mindmatters5
- Hub team introductions
- Disclosures
- Questions during presentations

Case Presentation

Dr. Deborah Edelman

Internal Medicine

Patient Information

Demographic Information	• 35 year old cis male • Medicaid • Employed full time (musician) • Lives alone
Medical History	• Alopecia

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Patient Information

Current Psychiatric Diagnoses	• Major Depressive Disorder (per patient)
Current Symptoms	**Depression** • PH-9 score of 21 • Anhedonia • Difficulty falling asleep with initial insomnia • Decreased appetite in the mornings but increased in the afternoon, gaining 7 pounds in 1 year • Feels slow overall • Difficulty concentrating • Lack of motivation • Feelings of hopelessness, helplessness, and/or guilt • Passive suicidal ideation **Anxiety** • Constant worry • Intrusive worrisome thoughts Says he has dealt with depressed feelings since diagnosed with Major Depressive Disorder (MDD) at age 27 with some periods of improvement that are overall short. Worsening of symptoms started 1 year ago. Feels depressed and sad all of the days of the week, for most of the day. Reduced pleasure when doing things he likes, including his work as a musician and other activities.
Current Substance Use Concerns	• Drinks alcohol monthly or less, cigars 1-2x per month

Patient Information

Past Psychiatric History	• First diagnosed with MDD at age 27 and treated with Bupropion with good results, but had to reduce dose due to depersonalization. Stopped Bupropion 8 years ago. • From ages 21-25 had a lot of energy, able to study and play music for over 12-14 hours daily, even sleeping at college to continue studying and playing. On one occasion only, patient felt he slept less than usual and didn't miss it. • Previous treatment with Wellbutrin 250
Family Psychiatric and Medical History	• Major Depressive Disorder — both mother and father
History of Trauma	• Not aware of trauma history

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Patient & Case Information

Current Treatment Plan for Psychiatric Conditions	• Refer to integrated behavioral health provider for assessment
Areas of Support and Consultation Being Sought	• Diagnostic clarification • Pharmacological consultation • Identify appropriate behavioral health referrals
Main Question	• Would it be safe to prescribe an SSRI in this patient given the delay in treatment time? Consider possible history of hypomania, significant suicidal ideation.

Understanding Suicide Risk: Assessing for a Rare and Unpredictable Event

Amy Bennett-Staub, RN, MPA
Behavioral Health Director of Safety and Quality
Mount Sinai Health System

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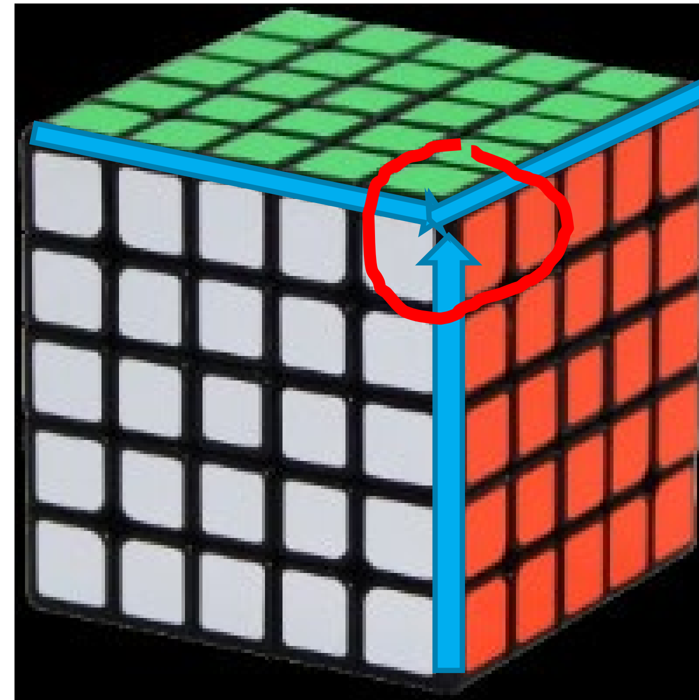
Suicide is a human condition

- Each patient has a unique combination of dynamic and enduring factors that contribute to the patient’s suicide risk
- The patient’s level of distress will vary over time so we need to **understand the nature, intensity, and frequency of the patient’s psychological pain**
    - **What may seem tolerable to the therapist may be totally intolerable to the patient**
    - **Individuals who are acutely suicidal feel pain akin to losing a limb**
    - **They do not want to die but see no other way out of their pain**

VULNERABILITY

PAIN

PERTURBATION



Tri-Axial Cube Model (Edwin S. Schneidman)

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Suicide Data: United States

Suicide is a public health problem and leading cause of death in the United States. Suicide can also be prevented – more investment in suicide prevention, education, and research will prevent the untimely deaths of thousands of Americans each year. Unless otherwise noted, this fact sheet reports 2019 data from the CDC, the most current verified data available at time of publication (January 2021).

47,511 Americans died by suicide making it the **10th leading cause of death**.

- **2nd** leading cause of death for ages 10-34
- **4th** leading cause of death for ages 35-44
- **36.6%** of people who died by suicide were 55 or older

12 million Americans have serious thoughts of suicide.

1.379 million Americans attempted suicide.

54% of Americans have been affected by suicide in some way.

Men died by suicide **3.63x** more often than females.

Females were **1.66x** more likely to attempt suicide.

60.29% of firearm deaths were suicides.

50.39% of all suicides were by firearms.

In 2019, the suicide rate was **1.5x higher for Veterans** than for non-Veteran adults over the age of 18.

90% of those who died by suicide had a diagnosable mental health condition at the time of their death.

Among adults with a diagnosed mental health condition **43.8%** did not receive mental health services in the past year.

73.1% of the United States did not have enough mental health providers to serve residents in 2020, according to federal guidelines.

See full list of citations at **afsp.org/statistics**.

American Foundation for Suicide Prevention

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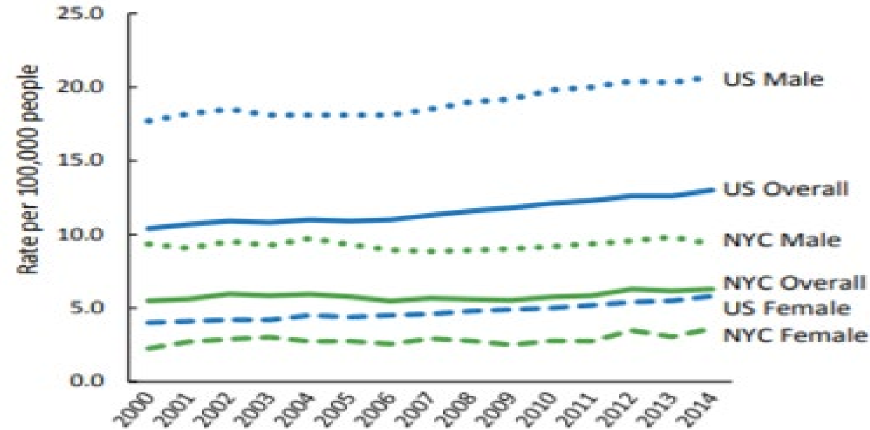
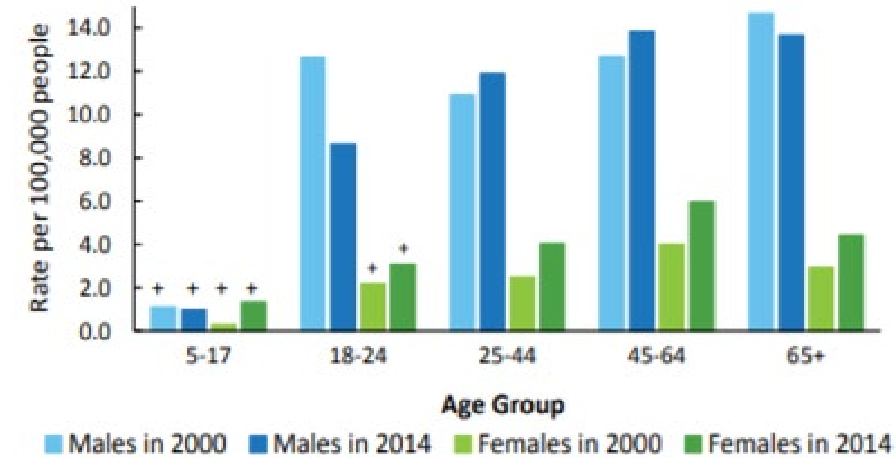
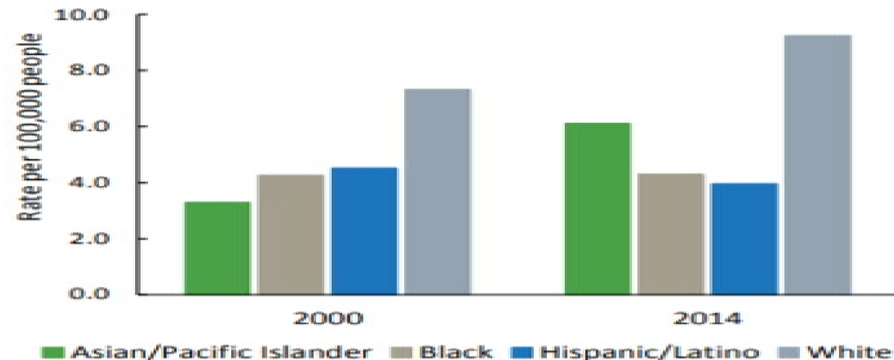
NYC Suicide Related Demographic Data



Sources: NYC DOHMH Bureau of Vital Statistics, 2000-2014; Curtin SC, Warner M, Hedegaard H. Increase in suicide in the United States, 1999–2014. NCHS data brief, no 241. Hyattsville, MD: National Center for Health Statistics. 2016



+ Interpret rates with caution due to the small number of events.
Source: NYC DOHMH Bureau of Vital Statistics, 2000-2014



Asian/Pacific Islander, Black, and White races exclude Hispanic/Latino ethnicity.
Source: NYC DOHMH Bureau of Vital Statistics, 2000-2014

ASSESSING SUICIDE

SCREENING VS. ASSESSMENT

Patient Health Questionnaire (PHQ-9) (Age 12+)

The PHQ-9 is a validated widely used nine-item tool used to diagnose and monitor the severity of depression using DSM depression criteria. Question 9 screens for the presence and duration of suicide ideation. PHQ-9 Score >= 10 OR Positive response to question 9 suggest more assessment.

Columbia-Suicide Severity Rating Scale (C-SSRS) (All Ages)

The C-SSRS looks at identified suicide attempts and also assesses the full range of evidence-based ideation and behaviors (intent, method and plan). It can be used in initial screenings or as part of a full assessment.

Example: SAFE-T with C-SSRS Columbia-Suicide Severity Rating Scale (C-SSRS) Risk Assessment Version

Patient Safety Screener (PSS-3) (Age 12+)

The PSS-3 is a brief tool to detect suicide risk in acute care settings that assesses depression, active suicidal ideation within the past two weeks, and lifetime suicide attempts. The ED-Safe Secondary Screener (ESS-6) is completed for further assessment.

Ask Suicide-Screening Questions (ASQ) screening tool (Age 10-24)

The ASQ is a set of four screening questions developed by NIMH to assess suicidal thoughts and behaviors. A Brief Safety Assessment is available to be used when patients screen positive.

Mount Sinai Health System Suicide Prevention Program
Using the Columbia-Suicide Severity Rating Scale (C-SSRS)—SCREENING FOR SUICIDE RISK

GENERAL GUIDANCE

- THE C-SSRS QUESTIONS ARE NOT DISCREET QUESTIONS—THEY BUILD UPON EACH OTHER
- THE FINAL RISK LEVEL IS NOT BASED ON THE ANSWER TO A SINGLE QUESTION, IT IS A COMPOSITE RISK
- LOGIC IS BUILT INTO EPIC TO ASSIGN THE CORRECT RISK LEVEL BASED ON THE ANSWERS TO THE QUESTIONS

C-SSRS QUESTION WORKFLOW

Ask Questions 1 and 2a and 2b, regardless of answer:	
ACTUAL QUESTION FOR PATIENT	*QUICK GUIDE FOR SCREENER*
1) In the past month have you wished you were dead or wished you could go to sleep and not wake up?	*This asks about **thoughts** about death*
2a) In the past month have you had any actual thoughts of killing yourself?	*This asks about **thoughts** of suicide, both recent in past month, and currently while in hospital*
2b) Do you have thoughts of hurting or killing yourself *right now?*	
If YES to 2a and/or 2b, ask questions 3, 4, 5, and 6. If NO to both 2a and 2b, go directly to question 6.	
ACTUAL QUESTION FOR PATIENT	*QUICK GUIDE FOR SCREENER*
3) In the past month have you been thinking about how you might do this?	*This asks about **method** of suicide*
4) In the past month have you had these thoughts and had some intention of acting on them?	*This asks about **intent** to commit suicide*
5) In the past month have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	*This asks about **plan/details** of how suicide may be committed*
6) In your *lifetime* have you ever done anything, started to do anything, or prepared to do anything to end your life?	*This asks about past actual **suicide attempts**, or **preparing** to commit suicide, even if patient never actually followed through on attempt*
If yes did you do anything in the *last 3 months*?	

RISK LEVEL BASED ON POSITIVE RESPONSE (LOGIC BUILT INTO EPIC)
If Answers to Q1, Q2a,Q2b and 6 are No, then No Risk

LOW RISK:
YES ONLY TO EITHER Q1 OR Q2a;
NO FOR ALL OTHERS

INTERVENTION
- Provider reviews mental health resources in AVS at discharge with patient

MODERATE *ACUTE* RISK:
YES TO Q3, AND NO to Q2b, Q4, Q5 AND Q6-Past 3 mos

INTERVENTIONS
- Provider orders psychiatric consult for **Suicide Risk Assessment** as soon as possible

MODERATE *LIFETIME* RISK:
YES TO Q6a, AND NO to Q2b, Q4, Q5, AND Q6-Past 3 mos

INTERVENTIONS
- Provider considers psychiatric consult for **Suicide Risk Assessment**
- Refer for outpatient behavioral health evaluation

HIGH RISK:
YES TO Q2b, Q4, Q5, AND/OR Q6-Past 3 mos,
REGARDLESS OF ANSWERS TO OTHERS

INTERVENTIONS
- Place patient on **1:1 Constant Observation**
- Notify ED provider
- Complete **Room Safety Guide**
- Provider orders psychiatric consult for **Suicide Risk Assessment** and **1:1 Constant Observation**

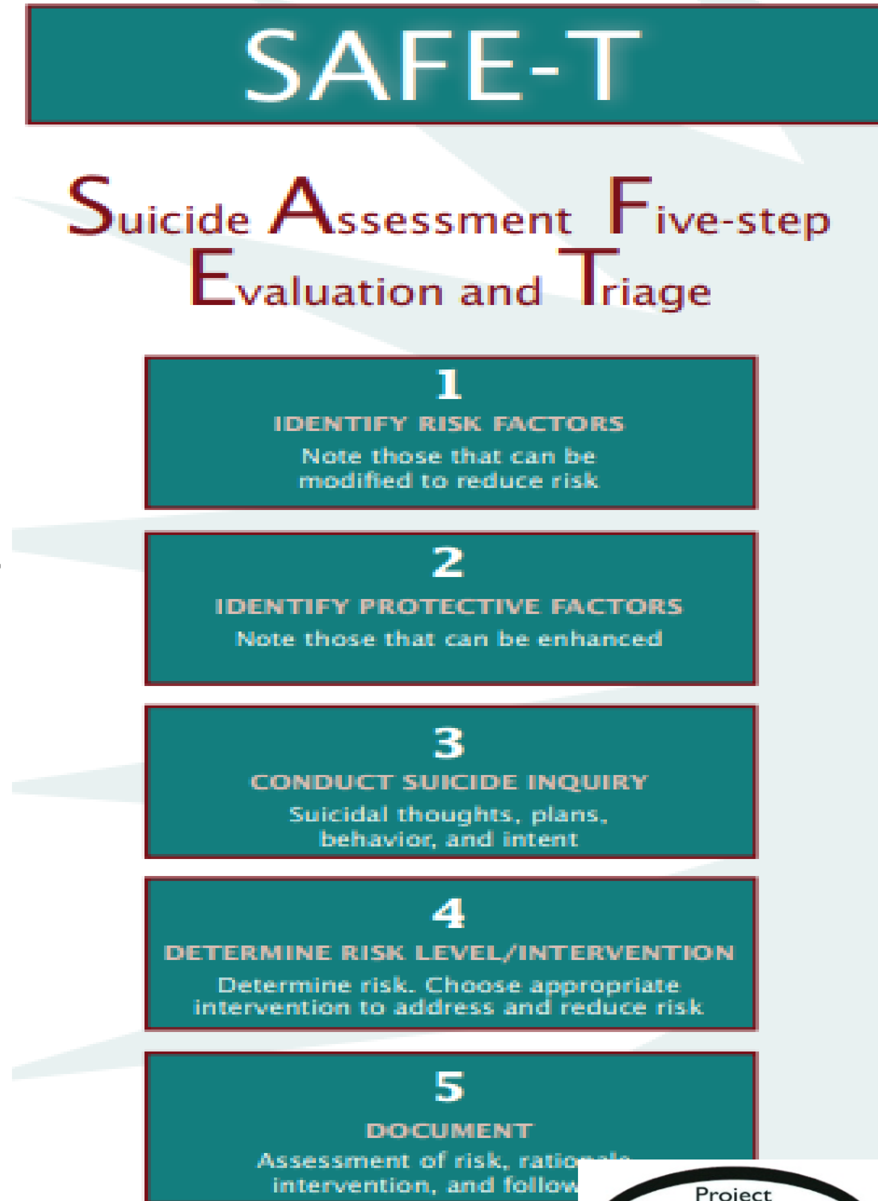
Understanding the Limitations of Screening Tools

- The prediction of who completes suicide is a mathematical impossibility
- Screening tools lack adequate specificity and sensitivity. Reliance on screens may result in false reassurance for false negatives and false positives may result in unnecessary interventions
  - About 50% of patients who die by suicide denied any suicidal ideation or behaviors at last visit. Reliance on verbalized or reported SI as a gateway to a suicide risk assessment is not identifying all patients at risk
  - About 50% of completed suicides are patients presumed to be at “low risk”
  - Most “high risk” patients will not die from suicide
  - Past suicide attempts is associated with suicide yet about 50% had no previous attempts.
- Screening tools do not assess other risk factors
- Implementation limitations (time, skill, comfort)

Suicide Risk Assessment

Suicide assessment is more comprehensive evaluation done to confirm suspected suicide risk by gathering more information, estimate the immediate danger to the patient, and decide on a course of treatment.

- Provides a structured way to engage with patients and their problems.
- Identifies risk and protective factors in addition to suicidal ideation and behaviors.
- Prioritizes and weighs risk and protective factors to determine risk.
- Targets factors for treatment recommendations and immediate safety interventions.



Identifying Risk Factors that make suicide more likely (see attached Acute and Chronic Risk Factors)

- **Risk factors charted for the majority of all decedents (with or w/o suicidal ideation)**
  (Berman, A. Risk Factors Proximate to Suicide and Suicide Risk Assessment in the Context of Denied Suicide Ideation**)**
  - H/O prior suicide ideation and/or suicide attempt
  - Acute anxiety/agitation/impulsivity and sleep problem
  - Acute interpersonal problems or job/financial strain
  - Comorbid diagnoses (Mental Illness)
  - Increasing use of alcohol and drugs
  - Social isolation/withdrawal
  - Family history of mental disorder and/or suicide

- **Other Warning Signs:**
  - Talking, reading, writing, researching death
  - Feeling hopeless, trapped or in unbearable pain
  - Putting affairs in order, giving things away
  - Extreme mood swings
  - Stock-piling medications or stopping medications

Risk and protective factors provide targets for treatment intervention and risk mitigation

- Decreasing risk factors generally decreases risk, and increasing protective factors generally decreases risk
- Acute factors (dynamic) are know to contribute appreciably to the assessment of short-term risk and arise from significant changes of existing chronic factor or completely new sources (recent loss or death)
- Chronic factor may impact suicide risk over one's lifetime and may be permanent and non-modifiable (age, h/o trauma or suicide attempts) or modifiable (reoccurrence of mental illness or substance use)

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Identifying Protective Factors

Accessible and responsive social support

- Connected to medical & psychiatric care
- Family/Friends cohesion and involvement

Meaningful activities

- Involvement in work, school, and community

Coping mechanisms

- Presence of good problem solving skills
- Ability to consider options

Dependents

- Children under 18 in the home
- Pregnancy

Other

- Cultural and religious beliefs that provide meaning and discourage suicide
- Multiple reasons for living
- Expression of hope for the future
- Fear of death or dying due to pain and suffering

Access to Means

Always inquire into access to and availability of any means and especially those that the individual is considering as part of a suicide plan:

- Firearms
- Pills, ingestible poisons
- Sharps
- High places such as rooftops, bridges
- Materials/opportunity for hanging or asphyxiation

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Beginning a Suicide Inquiry

Assess the patient's frequency and intensity of their suicidal thoughts

- **Ask patient about passive and active SI (passive vs. active SI)**
  - **Passive Suicide Ideation** is when you have thoughts of suicide or self harm but no plan to carry it out
  - **Active Suicide Ideation** is when you have thoughts of suicide or self harm, and have developed a plan.
- **Ask when they last had these thoughts (timing of most recent SI) and how often they have them**
- **Ask if they have attempted to hurt or kill themselves in the past (history of suicide attempts**
  - If so when did this occur, what happened and did they tell any one
- **If they are currently having thoughts of wanting to die or wanting to kill themselves**
- Ask if they have a plan and what the plan is
- **Assess the patients idea of what would happen if they followed through on their plan (intent)**
- **Ask if they have thoughts of hurting themselves with no desire to die (Non Suicidal Self Injurious Behavior - NSSIB)**
  - Ask if they do anything to hurt themselves , if so what do they do and what feeling is generated by doing it
  - As when they last engaged in NSSIB
  - Ask to show you where they cut, scratch, burn etc.

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Be Objective in Documenting Suicidal Behavior

KEY QUESTIONS:
Did the patient want to die? (degree of intent)
What did the patient expect to happen and what was the outcome?(medical lethality)

SELF-INJURY (NON-SUICIDAL)

- Self-injurious behavior (self mutilation) not intended as a desire to end life
- Acts symbolic of suicide not intended as a desire to end life (taking extra pills)

Note: act may unintentionally result in death; behavior may co-exist with suicidal behavior

SUICIDAL IDEATION

- Thoughts of engaging in suicide-related behavior

SUICIDE ATTEMPT

- Non-fatal, self-inflicted, potentially injurious behavior that individual believed would cause death

ABORTED SUICIDE ATTEMPT

- Individual initiates action to end their life but *stop themselves* before actually harming themselves

INTERRUPTED SUICIDE ATTEMPT

- Individual initiates action to end their lives but unexpectedly are stopped by *someone or something* external to the individual before actually carrying out the act

SUICIDE DEATH

- Individual took their own life with co intent by lethal means

References: https://www.healthquality.va.gov/guidelines/MH/srb/VADODCP_SuicideRisk_Full.pdf, https://www.sciencedirect.com/science/article/pii/S0165178115307678

Putting it all together and determining Risk

	LOW RISK	MODERATE RISK	HIGH RISK
CURRENT SUICIDE SELF-HARM RISK	• May have thoughts of death or even active suicidal thoughts w/o plan or intent • No recent history of suicidal behavior • Risk factors are modifiable or mostly distal/chronic • None or minimal acute/proximal risk factors or warning signs • Strong protective factors, including reason for living • Good social supports	• Suicidal ideation w/plan but no intent • No recent suicidal behavior • Multiple risk factors, but more distal/chronic than proximal/acute (suicide attempt in distant past, psychiatric diagnoses, trauma history) • Can anticipate a possible precipitant in the near future but none is imminent • No immediate access to means, but may be able to obtain them • Few or weak protective factors • More intact problem solving or coping skills • Has social supports that may be able to assist in maintaining safety	• Suicidal ideation w/ intent and plan, especially if the plan is imminent or lethal • Recent suicidal behavior (attempt, interrupted/ aborted attempt or preparatory behaviors) • Persistent ideation that feels uncontrollable, strong or intensely fluctuating intent, or suicide rehearsal • H/O of prior attempts with lethal method or impulsive attempts with little planning, especially if the circumstances around prior attempts resemble current or anticipated triggers • Has access or could easily obtain access to lethal means • Many acute/proximal risk factors and warning signs that outweigh protective factors • Psychiatric disorders with severe symptoms • Recent or anticipated acute precipitating events (such as trauma or loss) • Distressing change in situation or treatment • Few or no protective factors-particularly a sense of being a burden on others, extreme isolation with little support and feeling trapped.

RISK DETERMINATION TARGETS INTERVENTIONS

- Document assessment of risk, rationale, and interventions
- Suicide risk should be targeted w/ evidenced-based suicide-specific interventions that reduce modifiable risk factors and increase protective factors.
- Effective safety planning encourages individuals to call on a range of strategies to delay acting on suicidal urges.
- Ask about suicidal ideation, intent and behaviors at each visit
- Watch for other warning signs and increase contact when patient is in crisis
- With permission, involve members of the individual's support network to create a safety net.

High risk

- **Inpatient psychiatric admission or intensive outpatient care followed by outpatient treatment**
- **Other suicide precautions such as involving friends and family to create a social support safety net for close monitoring**
- **Safety Plan Intervention**
- **Structured Follow-up and Monitoring**

Moderate Risk

- **Possible inpatient admission**
- **Safety Plan Intervention with emergency and crisis plan**
- **Structured follow-up and monitoring**
- **Outpatient BH treatment**

Low Risk

- **Consider outpatient BH treatment**
- **Safety Plan Intervention including an emergency and crisis plan**
- **Med management**

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Appendix

ACUTE RISK FACTORS

Acute Symptoms of Mental Disorder (individual factors or in combination)

Acute Depression	Bipolar Disorder (active mood symptoms)
Insomnia (including persistent nightmares)	Depression following cocaine (or other) use
Psychosis (e.g. Command hallucinations to harm self or others, commit suicide)	
Active alcohol use disorder (particularly increased use relative to historical pattern)	

Acute Symptoms of Mental Disorder

Acute Depression	Bipolar Disorder (active mood symptoms)
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Acute Co-Morbid Mental Symptoms and Disorders

Acute Depression + Anxiety/Panic	Acute Depression + Agitation
Acute Depression + Alcohol Abuse	Schizophrenia + depressed mood, PTSD, and/or Active Alcohol Abuse
Borderline Personality Disorder + Depressed Mood	Acute Emotional Distress + Physical Illness
Burdon of having Multiple Physical Illnesses	Unremitting and /or Disabling Pain
Recent Diagnosis of a Life-Threatening or Disabling Illness + Depression	

Cognitive/Psychological Features

Hopelessness	Decreased Self-Esteem
Feelings of Being Trapped	Feelings of Loneliness
Feelings of Shame or Humiliation	Few/No Reasons for Living, Feeling Loss of Purpose or Meaning
Severe Anhedonia + Depressed Mood	Global Insomnia + Depressed Mood

Behavioral Features

Recent Violent Behavior	Final Act Behaviors (e.g. making last will, giving possessions away)
Increased Impulsive Behavior or Recklessness	Non-Suicidal Self Injurious Behavior
Evidence of Stalking and/or Preparations for Murder-Suicide	Few/No Reasons for Living, Feeling Loss of Purpose or Meaning

Psychosocial Issues

Lack of Social Support	Recent Loss/Disruption of a Relationship (Separation, Divorce)
Acute or Enduring Unemployment	Recent Discharge from Psychiatric Admission
Loss of Socioeconomic Status	Suicide Cluster (Contagion), Particularly with Adolescents
Financial Strain	Exposure to Suicide of a Peer or Someone Admired
Pending Legal Issues or Criminal Charges	Dramatic Media Coverage of a Suicide
Victim of Bullying (particularly in children & adolescents)	Racial Discrimination

CHRONIC RISK FACTORS

Past Self-Injurious & Suicidal Behavior*	
Past Suicidal Ideation/Plans/Attempts	Past Self-Injurious Behavior
*The absence of past suicidal ideation/attempts cannot be taken as an indicator of lower risk. It is estimated that >60% of suicides occur on the first attempt.	

Past Impulsive or Violent Behavior	
Past Impulsive Behavior	Past Reckless & Self-Endangering Behaviors
Past Violent Behavior	

Easy Access to Lethal Methods	
Guns in the Home	Hoarding of Medications

Mental Disorders (Predisposing & Potentially Modifiable Risk Factors)	
Mood Disorders (incl. MDD, Bipolar Disorder)	Substance Use Disorder (esp. Alcohol or Cocaine Use Disorder)
Schizophrenia	PTSD (particularly combat-related)
Personality Disorder (esp. Borderline, Antisocial)	Eating Disorders
Body Dysmorphic Disorder	Conduct Disorder (in adolescents)
Anxiety Disorder	Co-Morbid Disorders (Mood + Anxiety, Mood + Alcohol, Schizophrenia + Depression, PTSD + Alcohol, Borderline Personality + Depression)

Cognitive/Psychological Features or Traits	
Tunnel Vision	Limited Coping/Problem Solving Ability
Limited Capacity for Self-Soothing	Perfectionism
Absolutist Thinking	

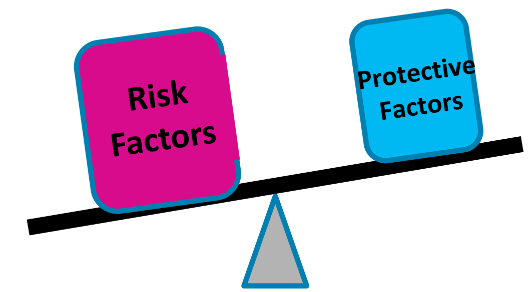
Medical Illness
Life Threatening or Increased Immobility & Pain

Socioeconomic Factors	
Barriers to Accessing Mental Health Care	Stigma or Barrier Related to Accessing Mental Health Care

Demographic Factors	
Male Gender	White or Native American Race/Ethnicity
Divorced, Widowed (particularly at young age), Separated, Single	Age (35-64, 75-85+), based on 2009 U.S. Suicide Data

Family/Peer Group Factors	
History of Sexual or Physical Abuse/Trauma as a Child or Adolescent	Family History of Suicide or Suicide Attempts
Family/Self Rejection of Sexual Orientation	Parental Divorce as a Young Child
Family History of Violence, Substance Abuse, or Psychiatric Disorders Requiring Admission	

Mitigating Suicide Risk Factors



Safety Planning

SAFETY PLAN
Step 1: Warning signs that I may not be safe
1.
2.
3.
Step 2: Remind myself of my reasons for living
1.
2.
3.
Step 3: Coping strategies that I use to distract myself or feel better
1.
2.
3.
Step 4: Social situations and people that can help distract me
1.
2.
3.
Step 5: People who I can ask for help
1.
2.
3.
Step 6: Professionals or agencies I can contact during a crisis
1.
2.
3.
4.
5.
Making my environment safe
1.

Warning Signs
Coping Strategies
Social Supports
Collaboration w/SO
Crisis Contacts

Treatment Planning

Address modifiable risk factors (Insomnia, Agitation, Substance Use, Psychosis, Pain, Anxiety, Psychosocial Stressors)

- Medical Treatments
  - Benzodiazepines
  - Antidepressants
  - Antipsychotics
  - Mood Stabilizers
- Psychosocial Treatments
  - Collaborative Assessment and Management of Suicidality (CAMS): https://cams-care.com/about-cams/
  - Cognitive Therapy for Suicide Prevention (CT-SP): https://www.med.upenn.edu/suicide/training.html
  - Dialectical Behavior Therapy (DBT): https://behavioraltech.org/resources/faqs/dialectical-behavior-therapy-dbt/
  - Attempted Suicide Short Intervention Program (ASSIP): A Novel Intervention For Those With A Recent Suicide Attempt: https://www.preventsuicideny.org/assip/
  - Screening, Brief Intervention and Referral to Treatment (SBIRT)
  - Psychoeducation